Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NEW MEXICO CENTER FOR FORENSIC
PSYCHOLOGY
801 GLENDALE ROAD
GLENVIEW IL 60025

Respondent Name
TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box
Number 05

MFDR Tracking Number
M4-13-0348-01

MFDR Date Received
October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted.

Amount in Dispute: $2258.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for a psychological evaluation with testing. The Provider submitted a request for preauthorization of psychological testing which was approved. Since the Provider was out of state, during discussions with the Carrier surrounding the preauthorization the Carrier informed the Provider that the Texas Workers' Compensation Fee Guidelines would govern reimbursement. The Provider…initially submitted billing for one unit of CPT code 96101…with a charge of $5,216.25. The Carrier…reimbursed the Provider for one unit of CPT code 96101 (as billed) in accordance with the Division-adopted Fee Guidelines. The Provider subsequently submitted billing for one unit of CPT code 96118…also with a charge of $5,216.25. Carrier …reimbursed…one unit of CPT code 96118 (as billed)…After requesting reconsideration of the billing for CPT code 96101, the Provider submitted this Request for Medical Fee Dispute Resolution…The Provider has never submitted billing for the remaining 17.5 hours of services, represented by additional units of the same CPT codes or submission of additional CPT codes, in his position statement. Reimbursement has been calculated and issued based on the billing submitted and in accordance with the appropriate Texas workers' compensation fee schedules. The Provider is not entitled to reimbursement…for services which were never billed to the Carrier.

Response submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	96101	$2258.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - W1 – workers compensation state fee schedule adjustment
   - 18 – duplicate claim/service
   - MC03 – subject to multiple procedure discounts and is paid at 100 percent of the fee schedule amount per the Texas physician fee schedule, Medicare guidelines

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Did the respondent make an appropriate reimbursement? Is additional reimbursement due?

Findings

1. The requestor provided services in the state of New Mexico on March 19, 2012 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. This dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307.

3. The requestor billed the disputed CPT code 96101 with CPT code 96118 on March 19, 2012. Per Medicare guidelines, multiple procedure discounting does not apply. The code descriptor for 96101 is "psychological testing…per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. The report states in part, "My hourly rate is $250 per hour and below is a breakdown of services rendered…The total billable hours were 19.5 and the final invoice comes to $5,216.25…" A review of the CMS-1500 indicates the requestor billed for one hour of CPT code 96101. 28 Texas Administrative Code §134.203 (b) states, For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…(2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Reimbursement for CPT code 96101 is calculated as follows:

   Division conversion factor of $54.86 ÷ Medicare conversion factor of $34.0378 x participating amount of $79.83 = $128.67 per hour. The CMS-1500 shows one hour billed. The insurance carrier paid $2957.85. No additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.